STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
2025 Small Group and Individual Group	)	DOCKET NOS. GMCB-005-24rr
Vermont Health Connect Rate Filing	)	GMCB-006-24rr
	)	
SERFF Nos. MVPH-134081005	)	
MVPH-134081032	)	

MVP'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

MVP Health Plan, Inc., ("MVP") by and through Primmer Piper Eggleston & Cramer PC, submits this Post-Hearing Memorandum to the Green Mountain Care Board (the "Board"), pursuant to Board Rule 2.307(g), in support of its 2025 Vermont Exchange Rate Filings (the "Rate Filings"), requesting an average rate increase of 15.9% for the Individual Market ("IM") and 12.8% for the Small Group Market ("SG").

The Board should approve MVP's rates as proposed because: (1) the Board and MVP actuaries agree that reductions present a significant risk of inadequate premium rates; (2) MVP's overall trend of multi-million dollar losses over the last 5 years in MVP's Vermont business unit are not sustainable; and, (3) MVP has satisfied all of the statutory criteria and provided additional and ample evidence this year of affordability, the promotion of quality care, and access to care.

Findings of Fact

I. MVP And L&E Agree That Reductions Below The Actuarial Recommendations As Amended At the Hearing Presents A Significant Risk of Inadequate Premium Rates. On May 13, 2024, MVP initially proposed an 11.68% rate increase for IM and a 9.34% rate increase for SG. *MVP's May 13, 2024 Rate Filings ("Rate Filings"), at Ex. 1, p. 2; Ex. 2, p. 2; Eric Bachner Testimony ("Bachner"), pp. 31–32.* The Board's actuary Lewis & Ellis, Inc.'s ("L&E") July 12, 2024 Actuarial Memoranda ("L&E Report") provided five

recommendations to the Board ("L&E Recommendations"). *Ex. 19, p. 19; Ex. 20, p. 17.* MVP agrees to each of L&E's Recommendations. *Bachner, pp. 35–38*. Taking MVP's original rate requests (11.68% rate increase for IM and a 9.34% rate increase for SG), and applying the L&E Recommendations[1] results in a net requested increase of 14.92% for IM and 11.52% increase for SG before adjustments for Hospital Budgets. *Ex. 26; Bachner, pp. 42–43*. MVP's calculations indicate that any adjustment for Brattleboro Retreat Budget Increases will have no impact on the proposed rates. *Bachner, p. 41*. As for Hospital Budgets, MVP calculated a new rate based on the assumption that the Hospital Budgets would be approved as proposed by the hospitals. *Bachner, 51–52; Exs. 24–26*. This results in an increase of 0.5% to IM and 0.8% increase to SG. *Id*. L&E agrees with these calculations. *Jacqueline Lee Testimony ("Lee"), p. 245*. MVP calculated that the combined resulting impact due to the modified trend inputs, updated risk transfer, House Bill H.766 and the Hospital Budget information results in a 15.5% increase for IM and a 12.39% increase for SG. *Bachner pp. 78–79*; *Ex. 26*.

At the July 24, 2024 rate hearing, MVP revised its rate request once more to incorporate the July 19, 2024 UVM additional budget increase request, resulting in proposed average rates of 15.9% for IM and 12.8% for SG. *Bachner, p. 80*. L&E agrees with these modifications to the proposed rates, assuming, like MVP, the Board adopts the hospital budgets as proposed. *Lee, p. 266*. Similarly, the Department of Financial Regulation ("DFR") agrees the proposed rates as modified would protect carrier solvency. *Jesse Lussier Testimony ("Lussier"), p. 226.* There is no opinion in evidence advanced by the actuaries or DFR that supports any reduction to the proposed rates, or opines that any reduction would result in an adequate rate and not threaten carrier

[1] Each year, MVP runs a "carrier calculation" through its rate filing software to check L&E's math in the L&E Report against its own data. *Ex. 22*. The application of L&E's recommendations using MVP's calculations, set forth in Exhibit 22, were agreed to by L&E. *Lee p. 266*.

solvency. Instead, L&E "strongly emphasize(d)" that reducing the CTR assumption "presents significant risk of inadequate premium rates that are not actuarially sound." *Ex. 19, p. 17.*

In this proceeding, the Board should focus on costs that are within MVP's control. Health care costs are the main driver of insurance rates. *Bachner, pp. 117–18.* The vast majority of every premium dollar goes towards health care costs. Administrative costs only account for between 5.8–6% of premiums. *Bachner, pp. 82.* This means health care claim costs account for more than 90% of pass-through expenses or "92 to 93 cents of every dollar." *Bachner, p. 82; 110.*

Focusing then on MVP's administrative costs for potential cuts, the Board should find, like L&E, that none are warranted in 2025. "MVP has atypically low administrative costs, despite not being a very large health plan" and it "therefore appears that MVP manages and limits administrative costs better than the typical health plan nationally." *Ex. 20, p. 13.* Administrative costs are in the first percentile as a percentage of premium. *Ex. 19, p. 15.* The actuaries agreed that whatever the Board decides on the pass through health care cost increases for 2025 in this proceeding should be as aligned as possible to the actual increases decided at the hospital budget hearings. *Bachner, pp. 51–52; Lee, p. 267.*

II. <u>Continued Multi-Million Dollar Losses In MVP's Vermont Business Are Not Sustainable.</u> MVP's multi-million dollar loss trend over the last five years was exacerbated by reductions to MVP's proposed rates. *See Ex. 27.*[2] Continued losses in SG and IM are not sustainable. *Bachner, pp. 75–76.* MVP lost $44.4 million on its Vermont book of business from 2019-2023. *Bachner, p. 64; Ex. 27.* Over the last five years, cuts based on L&E and Board recommendations, with which MVP did not agree, resulted in a total dollar impact of -$26.9 million projecting out to the end of 2024. *Ex. 27.* Regional not for profit plans need to remain

[2] Losses in 2024 are based on a high-level projection and by no means reasonably certain. *Bachner, p. 62.* Claim expenses and risk adjustment have not been completely accounted for yet in these projections. *Id.*

profitable in order to serve their communities. L&E found it "concerning" that MVP has experienced consistent, material losses in the last few years. *Ex. 19, p. 17; Lee p. 255*.

L&E strongly cautioned the Board against reducing MVP's risk margin, and MVP agrees. Healthy reserves allow MVP to continue to take risk, innovate and reinvest to the benefit of MVP's members, and protect against adverse experience relative to pricing assumptions. *Ex. 16, pp. 25–26*; *Ex. 1, p. 15; Ex. 2, p. 15*; *Bachner, pp. 65–66.* DFR and L&E both agree with MVP's 2025 proposed 1.5% CTR,[3] and that MVP's proposed CTR supports MVP solvency; it would not result in an inadequate rate after amendment to the proposed rate increases based on the agreed-on L&E recommendations and adjustments for the Hospital Budgets. *Lussier, pp. 225–26, 234–35; Bachner, pp. 87–88; Lee, pp. 256–57; Ex. 1, p. 15; Ex. 2, p. 15; Ex. 19, pp. 16–18; Ex. 20, pp. 14–15.* Additionally, and in light of uncertainty in the marketplace, if MVP were to suddenly take on a significantly larger share of the individual or small group market, the Vermont business would become a much larger portion of the overall MVP Health Plan business and, if the rates were inadequate, could "present problems for MVP's long-term solvency." *Bachner, p. 88.*

As a "reasonableness check," L&E reviewed rate filings nationwide and the 377 Qualified Health Plan (combined individual and small group) filings submitted in 2024. *Lee, pp. 250–51; Ex. 19, p. 17; Ex. 20, p. 15*. MVP's proposed CTR approximately places it in the 20th percentile for all 2024 QHP filings and is lower than the national average. *Id., Lee, p. 252*. The 2024-projected federal loss ratio for MVP using this CTR is 92.5% for IM and 92.4% for SG, significantly higher than the 80% statutory minimum, meaning that 92.4-5 cents on every premium dollar will go back to paying claims. *Ex. 19, p. 4; Ex. 20, p. 3*. MVP is not overcharging Vermonters. *Ex. 19, p. 19; Ex. 20, p. 17*.

[3] MVP's proposed CTR does not include a bad debt component. *Bachner, p. 68; Lee, p. 248*.

Additionally, the Board should not reduce the rates based on utilization trend because there is an inherent connection between the utilization trend and risk margin. L&E acknowledges that while a higher risk margin could be justified, a lower utilization trend assumption could also be justified. *Ex. 19, p. 17; Ex. 20, p. 15*. However, "[a] lower utilization trend would lead to a higher chance that MVP would not be able to retain all of that risk margin that was filed." *Bachner, p. 76*. This means adjusting one would necessarily impact the other, creating unwanted results and unnecessary solvency concerns. If the risk margin is cut, there would be significant concerns about the inadequacy of potential premium rates. *Bachner, pp. 76–77*. Thus, this "reasonableness check," moved L&E to "strongly emphasize[] that reducing the CTR assumption from the filed 1.5% presents significant risk of inadequate premium rates that are not actuarially sound." *Id*.; *Ex. 19, p. 17*. L&E use of stronger language this year emphasizes the risk posed by reductions to risk margin. Therefore, the Board should not cut risk margin for 2025.

Finally, the Board should approve the proposed rates using L&E's pharmacy trend numbers. When L&E submitted its actuarial memorandum and recommendations, it proposed blending the historical experience with the PBM's recommended trends to arrive at an average annual 13% pharmacy trend assumption, increasing the IM rate by approximately 1.2% and the SG rate by approximately 1.5%. *Ex. 19, pp. 9–10; Ex. 20, p. 9*. MVP agreed to this recommendation. *Ex. 26*. The Board should not ignore its own actuary's recommendations nor reduce MVP's pharmacy trend, a reduction that risks a resulting inadequate premium.

III. MVP Offered Substantial Evidence That It Is Lowering Costs, Promoting Quality Care, Access, And Affordability In This Rate Filing, And The Board Should Not Reduce The Proposed Rate Increases On Any Of These Bases. MVP has taken significant steps to contain costs and address affordability, access, and quality of care for 2025. MVP's broad suite

of initiatives and programs include: access to a nationwide network of providers, promotion of primary care, member guidance towards high quality and lower cost options and subsidies, and telehealth and telemedicine support. *Exs. 1–16, 22–27, 40; Bachner, pp. 89–101.* Arbitrary cuts on non-actuarial grounds increase the sustainability risk. See § 1, *supra*.[4]

MVP's telehealth program has impacted access to care, quality of care, and affordability by making it easier for people to access doctors even in rural areas where a physical office providing care may be far away, or after hours—and avoid costly trips to the ER. *Ex. 16, p. 9–10; Bachner, pp. 91–93.* Telehealth has reduced the amount of care utilized on location at various facilities, thus necessarily reducing associated health care costs. *Ex. 16, p. 9–10; Bachner, pp. 91–93.* Also, MVP encourages strong relationships with PCPs. This supports the three non-actuarial criteria because the PCP is the first line of defense for a member's health, able to triage needs and potential resources expended to identify and solve health issues while providing quality care by having familiarity with the patient's background. *Ex. 16, p. 10; Bachner, pp. 93–96.*

MVP's case management programs also create efficiencies that improve affordability, quality, and access to care. *Ex. 16, pp. 11–12*; *Bachner, p. 96.* The programs assist with management of chronic conditions and acute cases, providing specialized services and treatments that are necessary for the member to get the best quality treatment possible in the most efficient manner. *Ex. 16, pp. 11–12; Bachner, pp. 96–98.* Furthermore, MVP's competitive bidding process utilized to explore new vendors ensures they contract with vendors who will provide quality services at the most affordable costs. *Ex. 16, pp. 11–12; Bachner, pp. 99–101.*

[4] Affordability is a broad economic and public policy issue that is largely beyond the control of insurance carriers, and the scope of these insurance rate proceedings. For example, a determination of "affordability" is directly related to a given individual's income and other life costs. *Testimony of Mike Fischer, p. 291.* Further, during the pre-rate review plan design process the Department of Vermont Health Access ("DVHA") and other stakeholders independently consider affordability and "bake it" into the plan designs, consistent with the guard rails of federal law. *Bachner, pp. 116–18.*

MVP wants healthy members and offers a well-being program for non-standard plans that provides up to $600 per subscriber in reimbursements for items that will improve health. *Ex. 12, p. 1; Ex. 16, p. 6; Bachner, pp. 101–03, 219–20.* Because MVP recognizes health care decisions often begin before a person goes to the doctor, it provides opportunities for members to become healthier by way of enrolling in well-being programs, which MVP believes will increase the health of its members and reduce subsequent medical costs and future premium rates. *Bachner, pp. 102–03.*

In addition to MVP-specific programs, there are tools that are statutorily required, which make health insurance affordable for vast swaths of Vermonters: the cost-sharing reduction program and the advance premium tax credits. *Bachner, pp. 106–07*. The former allows lower income members to receive discounts on services resulting in lower deductibles, out of pocket maxes, co-pays and co-insurances. *Bachner, p. 106*. MVP's silver-loading strategy has helped ensure the continued benefit of this program despite federal government defunding. *Bachner, pp. 106–07*. The advance premium tax credits cap a member's premium rate in accordance with their income on a sliding scale—including for individuals earning even more than 500% of the federal poverty level. *Bachner, pp. 107, 151–52*; *Ex. 16, p. 16–17*. These two tools increase affordability by reducing premiums and out of pocket expenses, and increasing access to care and quality of care for individuals across a variety of income levels. *Bachner, p. 108*. Additionally, the state and federal governments have created subsidies and safety nets for individuals to address affordability through Vermont Health Connect, Medicare, and Medicaid, and thus have already effectively determined what is affordable for each particular Vermonter. *Ex. 16, p. 16–17; 24–25*; *Bachner, pp. 118–119.*

MVP has met is burden that the proposed rates are affordable, promote access to care, and promote quality care, and therefore should not be reduced on non-actuarial statutory grounds.

Conclusions of Law

1. Health insurance rates in Vermont must be approved before they are implemented. 8 V.S.A. §§ 4062(a) and 5104(a). The Board is empowered to approve, modify, or disapprove requests for health insurance rates. 18 V.S.A. § 9375(b)(6); 8 V.S.A. § 4062(a). MVP bears the burden of demonstrating that its rates satisfy the statutory criteria. *Board Rule 2.104(c)*. The Board must consider changes in health care delivery, changes in payment methods and amounts, DFR's solvency analysis, and other issues at the discretion of the Board. *Board Rule 2.401*. The Board shall modify or disapprove a rate request only if it is unjust, unfair, inequitable, misleading, or contrary to law, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the insurer's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access. 8 V.S.A. §§ 5104(a) and 4062(a)(2)-(3); *Board Rule 2.000*. Each piece of evidence in the record could apply to one, multiple, or all of these statutory criteria. All of the statutory criteria are interrelated.

2. MVP's proposed rate increases are adequate and not excessive because they provide for and do not exceed the rates needed to satisfy the Board approved plan-designs, provide for all expected costs, including health benefits, health benefit settlement expenses, rising health care costs, marketing and administrative expenses, and the cost of capital for the benefit year. *Bachner, pp. 123–25.* They are not unfairly discriminatory because they do not result in premium differences among the insured within similar risk categories that are not permissible under applicable law, or do not reasonably correspond to differences in expected costs. *Id*. The proposed premiums are reasonable relative to the benefits that are included in the Rate Filings, and will

maintain minimum solvency requirements in 2025. *Bachner, pp.125–27; Lussier, pp. 228–29; Ex. 17, p. 2; Ex. 18, p. 2.* Based on the Rate Filings and all the other evidence submitted at the Hearing, including testimony, the rates are not unjust, inequitable, misleading, nor contrary to Vermont law because they are actuarially sound and fairly charge a premium for services covered, and are reasonable based on the data that MVP and L&E analyzed. *Bachner, pp. 123–27.*

3. The Board must consider affordability, promotion of quality care and access to care in a "fair, predictable, transparent, [and] sustainable" manner. *In re MVP Health Ins. Co.*, 203 Vt. 274, 284 (2016); *2021 Vermont Health Connect Rate Filing Decision, SERFF No. MVPH-*132371260, p. 15 ("[r]elated to the affordability criterion in the Board's rate review process is the expectation that MVP provide benefits and services at minimum cost under efficient and economical management. *See 8 V.S.A. §§ 4513(c), 4584(c), 5104(b).*"). MVP's rate filings and other evidence produced at the Hearing support a conclusion that MVP's rates meet the standard of affordability. *Bachner, p. 123*. MVP has established that a rate increase of 15.89% for IM and 12.81% for SG are actuarially sound, assuming the as-proposed hospital budgets. *Bachner, pp. 126–27*. If the Board modifies the proposed rates, that decision should be based on evidence in the record, satisfy *all* statutory criteria, and result in a balanced rate. *In re MVP Health Ins. Co.*, 203 VT at 286. A reduction on non-actuarial grounds may result in an inadequate, unsustainable rate. *Bachner, p. 127; Lee, p. 255; Ex. 19, p. 17; Ex. 20, p. 15.*

4. This year DFR concurred that MVP's original and revised proposed rate increases are adequate to protect MVP's solvency, contingent on L&E's opinions. 8 V.S.A. §4062(a)(3); *Bachner, pp. 86–88; Lussier, p. 226; Ex. 18, p. 2; Ex. 19, p. 2.* L&E also agreed that the rates as revised were not inadequate or excessive in light of the proposed Hospital Budgets while cautioning against any further cuts. *Lee, p. 266; Ex. 19.*

5. Based on all of the substantial evidence, the Board should accept L&E's Recommendations; and find that MVP has met its burden of proving that the Rate Filings, with a 15.9% increase for IM and a 12.8% increase for SG, assuming the as-proposed hospital budgets, meet all of the statutory criteria. 8 V.S.A. §§ 4062(a); 5104(a); and, 18 V.S.A. § 9375(b); *Exs. 1–16, 22–27, 40; Bachner, pp. 22–223; Bachner (Confidential Hearing Transcript), pp. 3–26; Lussier, pp. 223–38; Lee, pp. 238–86; MVP's August 2, 2024 Responses to Post-Hearing Board Questions.*

CONCLUSION

As Board Chair Foster aptly noted, "these are really tough times." Health care is expensive for Vermonters, hospitals need to ensure solvency so people have access to health care, and "if you reduce the insurers, there's real insolvency problems." *Testimony of Chair Foster, pp. 298–99.* Health care ***insurance*** regulation is driven largely by those larger health care cost challenges. The Board's and MVP's actuaries agree on 15.9% IM and 12.8% SG rate increases, based on the assumption that the hospital budgets requests are approved as filed. L&E identified a "significant risk" of inadequate premiums if rates are cut. Any non-actuarial reduction to the rates as proposed increases this risk, and would be contrary to the substantial evidence on non-actuarial criteria MVP provided this year. The continued trend of MVP's multi-million dollar losses threatens the continued sustainability of MVP's Vermont book of business. MVP respectfully requests that the Board approve the proposed rates.

Dated: August 5, 2024

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